UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

ANTONIO ZALAZAR, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner, Social Security Administration, Defendant.	No. EDCV 06-1248 (CW) DECISION AND ORDER

The parties have consented, under 28 U.S.C. § 636(c), to the jurisdiction of the undersigned Magistrate Judge. Plaintiff seeks review of the Commissioner's denial of disability benefits. As discussed below, the court finds that the Commissioner's decision should be reversed and this matter remanded for payment of benefits for the period between May 17, 1997, to March 21, 2000.

I. BACKGROUND

Plaintiff Antonio Zalazar was born on June 12, 1948, and was fifty-one years old during the period relevant to his Disability Insurance Benefits ("DIB") claim. [Administrative Record ("AR"), 152.]

He has a fifth grade education in Mexico and past relevant work experience as a machinist and cook. [AR 43, 223.] Plaintiff alleges disability on the basis of lower back pain, beginning on September 9, 1994. [AR 222.] On March 22, 2000, plaintiff resumed substantial gainful activity as a machine operator. [AR 21.] Plaintiff seeks a closed period of disability from September 9, 1994, to March 21, 2000. [Joint Stipulation ("JS") 4.]

II. PRIOR PROCEEDINGS

Plaintiff initially filed a protective application for Disability Insurance Benefits under Title II of the Social Security Act on November 20, 1995, alleging disability since September 9, 1994. [AR 69.] The application was eventually denied in an administrative decision filed on May 16, 1997. [AR 69-79.] The Appeals Council declined review on November 20, 1998. [AR 88-89.]

In the interim, plaintiff filed a second DIB application on November 26, 1997. [JS 1, AR 152-54.] After the application was denied initially and upon reconsideration, plaintiff requested an administrative hearing, which was held on October 14, 1999, before Administrative Law Judge ("ALJ") Gary D. Admire. [AR 40.] Plaintiff appeared with counsel, and testimony was taken from plaintiff and third-party witness Jessie Zalazar. [Id.] The ALJ denied benefits in a decision dated January 27, 2000. [AR 101-09.] On April 17, 2000, the Appeals Council remanded the matter for further proceedings in light of additional evidence that the date last insured for purposes of plaintiff's DIB eligibility had been extended, among other things. [AR 132-33.]

An administrative hearing was subsequently held on July 25, 2001, before ALJ Keith Varni. [AR 33.] Plaintiff appeared with counsel and

testified. [Id.] The ALJ denied benefits in a decision dated August 21, 2001. [AR 19-24.] On July 31, 2002, the Appeals Council declined review. [AR 5-6.]

Plaintiff filed a complaint in the district court on September 24, 2002 (Case No. EDCV 02-1029). The matter was remanded for further administrative proceedings pursuant to a stipulation between the parties on March 25, 2005. [AR 535-36.]

An administrative hearing was subsequently held on April 27, 2006, before ALJ Varni. [AR 666-673.] Plaintiff did not appear for the hearing, although plaintiff's counsel did, and testimony was taken from vocational expert Sandra Fioretti. [AR 669.] The ALJ denied benefits in a decision dated June 3, 2006. [AR 519-25.] When the Appeals Council denied review on September 18, 2006, the ALJ's decision became the Commissioner's final decision. [AR 510-12.]

The instant complaint was filed on November 14, 2006. On May 29, 2007, defendant filed an answer and plaintiff's Administrative Record ("AR"). On August 3, 2007, the parties filed their Joint Stipulation ("JS") identifying matters not in dispute, issues in dispute, the positions of the parties, and the relief sought by each party. This matter has been taken under submission without oral argument.

III. STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), a district court may review the Commissioner's decision to deny benefits. The Commissioner's (or ALJ's) findings and decision should be upheld if they are free of legal error and supported by substantial evidence. However, if the court determines that a finding is based on legal error or is not supported by substantial evidence in the record, the court may reject the finding and set aside the decision to deny benefits. See Aukland

v. Massanari, 257 F.3d 1033, 1035 (9th Cir. 2001); Tonapetyan v. Halter, 242 F.3d 1144, 1147 (9th Cir. 2001); Osenbrock v. Apfel, 240 F.3d 1157, 1162 (9th Cir. 2001); Tackett v. Apfel, 180 F.3d 1094, 1097 (9th Cir. 1999); Reddick v. Chater, 157 F.3d 715, 720 (9th Cir. 1998); Smolen v. Chater, 80 F.3d 1273, 1279 (9th Cir. 1996); Moncada v. Chater, 60 F.3d 521, 523 (9th Cir. 1995)(per curiam).

"Substantial evidence is more than a scintilla, but less than a preponderance." Reddick, 157 F.3d at 720. It is "relevant evidence which a reasonable person might accept as adequate to support a conclusion." Id. To determine whether substantial evidence supports a finding, a court must review the administrative record as a whole, "weighing both the evidence that supports and the evidence that detracts from the Commissioner's conclusion." Id. "If the evidence can reasonably support either affirming or reversing," the reviewing court "may not substitute its judgment" for that of the Commissioner. Reddick, 157 F.3d at 720-721; see also Osenbrock, 240 F.3d at 1162.

IV. DISCUSSION

A. THE FIVE-STEP EVALUATION

To be eligible for disability benefits a claimant must demonstrate a medically determinable impairment which prevents the claimant from engaging in substantial gainful activity and which is expected to result in death or to last for a continuous period of at least twelve months. Tackett, 180 F.3d at 1098; Reddick, 157 F.3d at 721; 42 U.S.C. § 423(d)(1)(A).

Disability claims are evaluated using a five-step test:

> Step one: Is the claimant engaging in substantial gainful activity? If so, the claimant is found not disabled. If not, proceed to step two.
>
> Step two: Does the claimant have a "severe" impairment? If so, proceed to step three. If not, then a finding of not

> disabled is appropriate.
>
> Step three: Does the claimant's impairment or combination of impairments meet or equal an impairment listed in 20 C.F.R., Part 404, Subpart P, Appendix 1? If so, the claimant is automatically determined disabled. If not, proceed to step four.
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> Step four: Is the claimant capable of performing his past work? If so, the claimant is not disabled. If not, proceed to step five.
>
> Step five: Does the claimant have the residual functional capacity to perform any other work? If so, the claimant is not disabled. If not, the claimant is disabled.

Lester v. Chater, 81 F.3d 821, 828 n.5 (9th Cir. 1995, as amended April 9, 1996); see also Bowen v. Yuckert, 482 U.S. 137, 140-142, 107 S. Ct. 2287, 96 L. Ed. 2d 119 (1987); Tackett, 180 F.3d at 1098-99; 20 C.F.R. § 404.1520, § 416.920. If a claimant is found "disabled" or "not disabled" at any step, there is no need to complete further steps. Tackett, 180 F.3d 1098; 20 C.F.R. § 404.1520.

Claimants have the burden of proof at steps one through four, subject to the presumption that Social Security hearings are non-adversarial, and to the Commissioner's affirmative duty to assist claimants in fully developing the record even if they are represented by counsel. Tackett, 180 F.3d at 1098 and n.3; Smolen, 80 F.3d at 1288. If this burden is met, a prima facie case of disability is made, and the burden shifts to the Commissioner (at step five) to prove that, considering residual functional capacity ("RFC")[1], age, education, and work experience, a claimant can perform other work

[1] Residual functional capacity measures what a claimant can still do despite existing "exertional" (strength-related) and "nonexertional" limitations. Cooper v. Sullivan, 880 F.2d 1152, 1155 n.s. 5-6 (9th Cir. 1989). Nonexertional limitations limit ability to work without directly limiting strength, and include mental, sensory, postural, manipulative, and environmental limitations. Penny v. Sullivan, 2 F.3d 953, 958 (9th Cir. 1993); Cooper, 800 F.2d at 1155 n.7; 20 C.F.R. § 404.1569a(c). Pain may be either an exertional or a nonexertional limitation. Penny, 2 F.3d at 959; Perminter v. Heckler, 765 F.2d 870, 872 (9th Cir. 1985); 20 C.F.R. § 404.1569a(c).

which is available in significant numbers. Tackett, 180 F.3d at 1098, 1100; Reddick, 157 F.3d at 721; 20 C.F.R. § 404.1520, § 416.920.

B. THE ALJ'S EVALUATION IN PLAINTIFF'S CASE

Here, the ALJ found that plaintiff had not engaged in substantial gainful activity during the period relevant to his DIB application (step one); that plaintiff had "severe" impairments, namely his lumbar spine disorder (step two); and that plaintiff did not have an impairment or combination of impairments that met or equaled a "listing" (step three). [AR 23.] Plaintiff was found to have an RFC for work at the medium exertional level, which would preclude his past relevant work (step four). [AR 23-24.] Based on plaintiff's age, education, work experience and RFC, as reflected in Rules 203.19 and 203.26 of the Medical Vocational Guidelines ("Grids"), plaintiff was found "not disabled" under the Social Security Act (step five). [AR 24.]

C. ISSUES IN DISPUTE

The parties' Joint Stipulation identifies two disputed issues:

1. Whether the ALJ properly evaluated the opinion of the examining physician; and
2. Whether the ALJ properly evaluated the opinion of the treating physician.

[JS 3.]

D. ISSUE ONE: THE EXAMINING PHYSICIAN'S OPINION

In July 1994, plaintiff sustained a herniated disc in his lower back while helping co-workers carry a piece of heavy machinery. [AR 263.] Treatment through physical therapy and epidural injections was unsuccessful. [AR 364.] In January 1998, plaintiff underwent a complete orthopedic consultation performed by Dr. Herbert Johnson. [AR

295-300.] Dr. Johnson recorded plaintiff's history, reviewed his medical records and performed a physical examination before concluding that plaintiff had "chronic low back pain." [AR 299.] Dr. Johnson also commented that plaintiff exhibited "quite marked pain behavior, which precluded an adequate evaluation of the musculoskeletal system" and that, "The patient at the present time seems to demonstrate genuine chronic pain behavior." [AR 299, 300.] Dr. Johnson recommended, from a functional standpoint, that plaintiff lift less then ten pounds frequently or occasionally, stand or walk less than two hours in an eight-hour workday, sit for one hour without a change, and avoid climbing, balancing, stooping, crouching, kneeling and crawling, among other limitations. [AR 300.] Several months after the examination, in September 1998, plaintiff underwent a laminectomy and open diskectomy. [AR 366.]

In the latest administrative decision, the ALJ incorporated his discussion of the medical evidence set out in his previous decision of August 21, 2001. [AR 520.] In that earlier decision, the ALJ gave "little weight" to Dr. Johnson's opinion because the doctor chose to discount "the virtually admitted signs of symptom exaggeration and fully credit the claimant's subjective complaints."[2] [AR 22.] Plaintiff argues that the ALJ's incorporated evaluation did not follow the court's order of remand and did not include legally sufficient reasons to discount Dr. Johnson's opinion. [JS 5.]

Ninth Circuit cases distinguish among the opinions of three types

[2] As evidence of symptom exaggeration, the administrative decision cited an August 1998 examination of plaintiff revealing positive Waddell's signs, "which are indicative of at least symptom magnification." [AR 21, 339.] The decision also cited an April 1999 pain management evaluation that noted some exaggeration of pain symptoms. [AR 22, 427.]

of physicians: those who treat the claimant (treating physicians), those who examine but do not treat the claimant (examining or consultative physicians), and those who neither examine nor treat the claimant (non-examining physicians). Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995). The opinion of a treating physician is given deference because he is employed to cure and has a greater opportunity to know and observe the patient as an individual. Sprague v. Bowen, 812 F.2d 1226, 1230 (9th Cir. 1987). The opinion of an examining physician is, in turn, entitled to greater weight than the opinion of a non-examining physician. Lester, 81 F.3d at 830. As is the case with the opinion of a treating physician, the ALJ must provide "clear and convincing" reasons for rejecting the uncontradicted opinion of an examining physician, and specific and legitimate reasons supported by substantial evidence in the record to reject the contradicted opinion of an examining physician. Id. at 830-31.

Here, the rationale provided to give little weight to Dr. Johnson's opinion – that he ignored signs plaintiff was engaging in symptom magnification and fully credited plaintiff's subjective complaints – was not a specific and legitimate reason supported by substantial evidence. Dr. Johnson's evaluation does not indicate that he ignored the possibility of symptom magnification by plaintiff; the evaluation indicates that he gave full consideration to the behavioral aspect of plaintiff's pain symptoms and concluded that the behavior was genuine. Moreover, Dr. Johnson's opinion was not grounded on plaintiff's subjective complaints, but on a comprehensive consultation including a medical history, a review of the medical records and a complete physical examination. Under these circumstances, the rejection of Dr. Johnson's opinion, without an explanation as to why

it was less persuasive than other opinions in the record containing fleeting references to possible symptom magnification, was not legitimate under the Ninth Circuit's standard. See Lester, 81 F.3d at 830-31.

E. ISSUE TWO: THE TREATING PHYSICIAN'S OPINION

Plaintiff's treating physician during this period was Dr. Daniel Franco. [AR 353.] In August 1999, approximately one year after plaintiff's back surgery, Dr. Franco completed a Physical Capacities Evaluation recommending that plaintiff be limited to lifting or carrying five pounds occasionally; sitting, standing or walking for one hour during an eight-hour workday; and no bending, squatting, crawling, climbing or reaching. [Id.] Concurrently, Dr. Franco wrote a treatment note stating that plaintiff continued to have severe low back pain after the surgery and was in a "depressed mood" and "mildly stressed" about it. [AR 463.] Dr. Franco also observed that plaintiff had five out of five possible Waddell's criteria. [Id.] Dr. Franco concluded, consistent with his physical capacities evaluation, that plaintiff "is still disabled."[3] [Id.]

The ALJ gave "little or no weight" to Dr. Franco's opinion, citing the following reasons: (1) the repeated findings of symptom exaggeration by better qualified examining medical sources; (2) the lack of evidence of any significant medically determinable mental impairment; and (3) the inconsistency of the objective findings and the reported symptoms. [AR 22.] Plaintiff contends the ALJ failed to

[3] Subsequently, in July 2001, after plaintiff resumed substantial gainful activity, Dr. Franco completed another Physical Capacities Evaluation which stated, as did the earlier evaluation, that plaintiff could sit, stand or walk for one hour during an eight-hour workday; occasionally lift or carry five pounds; and never bend, squat, crawl, climb or reach. [AR 497.]

provide specific and legitimate reasons to reject Dr. Franco's opinion. [JS 13.]

First, it is evident from Dr. Franco's August 1998 treatment note that he did not ignore signs of possible symptom exaggeration by plaintiff; the note indicates that the doctor took into account the positive Waddell's signs before concluding that plaintiff was still disabled.[4] Second, as for the lack of evidence of any significant medically determinable mental impairment, Dr. Franco's opinion cannot reasonably be construed to allege a significant mental impairment, only that plaintiff felt "depressed" and "slightly stressed" about his pain. Third, as for the purported inconsistency of the objective findings and the symptoms reported by Dr. Franco, this general finding is not sufficiently specific under the Ninth Circuit standard for the evaluation of treating medical evidence. See Regenitter v. Commissioner of the Social Security Administration, 166 F.3d 1294, 1299 (9th Cir. 1999)(quoting Embrey v. Bowen, 849 F.2d 418, 421 (9th Cir. 1988)) ("To say that medical opinions are not supported by sufficient objective findings or are contrary to the preponderant conclusions mandated by the objective findings does not achieve the level of specificity our prior cases have required"). Under these

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[4] Moreover, the purported evidence of plaintiff's symptom exaggeration cited in the decision is neither conclusive nor substantial. See note 2, supra. Despite indications of positive Waddell's signs, no physician explained the significance of the signs or interpreted them to mean that plaintiff was malingering or magnifying his symptoms. In addition, the single record that commented that plaintiff "appeared" to show symptom exaggeration still delineated objective physical findings justifying several treatment recommendations, including an increase in painkiller dosage, nerve root blocks, a neuropsychology referral, physical therapy, and a TENS unit. [AR 429.] The issue of symptom magnification was not as central to this case as the administrative decision appears to suggest.

circumstances, the evaluation of the treating medical evidence was not supported by specific and legitimate reasons based on substantial evidence in the record. See Lester, 81 F.3d at 830.

F. REMAND FOR PAYMENT OF BENEFITS

The decision whether to remand for further proceedings is within the discretion of the district court. Harman v. Apfel, 211 F.3d 1172, 1175-1178 (9th Cir. 2000). Where there are outstanding issues that must be resolved before a determination can be made, and it is not clear from the record that the ALJ would be required to find the claimant disabled if all the evidence were properly evaluated, remand is appropriate. Id. at 1179. However, where no useful purpose would be served by further proceedings, or where the record has been fully developed, it is appropriate to exercise this discretion to direct an immediate award of benefits. Id. (decision whether to remand for further proceedings turns upon their likely utility).

In plaintiff's case, as discussed above, the administrative decision did not include specific and legitimate reasons supported by substantial evidence in the record to reject the opinions of Dr. Johnson and Dr. Franco. Accordingly, their opinions are credited as true. Harman, 211 F.3d at 1178; Lester, 81 F.3d at 834. The vocational expert testified that a person with the limitations described in Dr. Johnson's opinion (the more conservative of the two opinions) could not perform plaintiff's past relevant work or any other work. [AR 671-72.] When the credited opinions are taken together with the vocational evidence, the record clearly indicates that plaintiff must be found disabled and entitled to benefits for the

closed period between May 17, 1997, to March 21, 2000.[5] Accordingly, no useful purpose would be served by further proceedings, and an order directing an immediate award of benefits is appropriate.

V. ORDERS

Accordingly, **IT IS ORDERED** that:

1. The decision of the Commissioner is **REVERSED**.

2. This action is **REMANDED** to defendant for payment of benefits.

3. The Clerk of the Court shall serve this Decision and Order and the Judgment herein on all parties or counsel.

DATED: September 28, 2007

_____/S/ _____
CARLA M. WOEHRLE
United States Magistrate Judge

[5] Plaintiff seeks benefits for the closed period between September 9, 1994, to March 21, 2000. [JS 4.] However, the record indicates that an ALJ decision denying benefits issued on May 16, 1997, is administratively final and has not been appealed or reopened. [AR 69-79.] Because this decision is not subject to judicial review, benefits for the period prior to the date of the decision cannot be awarded. See Califano v. Sanders, 430 U.S. 99, 108, 97 S. Ct. 980, 51 L. Ed. 2d 192 (1977).